MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

14242

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City ..... (No. 1130 N. 21st St. ..... Ward)

File No. .....

Registered No. 3580

2. FULL NAME Samuel Walker

(a) Residence. No. 1130 N. 21st St., N Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Mail	Cold	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11 1900

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
29	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labore
(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Henderson
(STATE OR COUNTRY) Ky

PARENTS

10. NAME OF FATHER Samuel Walker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Henderson
(STATE OR COUNTRY) Ky

12. MAIDEN NAME OF MOTHER Mattie Marshall

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Henderson
(STATE OR COUNTRY) Ky

14. INFORMANT Homer Marshall
(Address) 3736 Finney

15. FILED APR 11 1930 Max C. Tarkenny REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9 1930

17. I HEREBY CERTIFY, That I attended deceased from Wed 28, 1930, to April 9, 1930 that I last saw him alive on April 7, 1930 and that death occurred, on the date stated above, at 2.20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

66B

108 (duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Hyperthryodium

(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. B. Moore, M. D.

4 9, 1930 (Address) 1336 Franklin

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Washington Park	April 12 1930
20. UNDERTAKER	ADDRESS
C. DeVault	707 N Leonard

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.